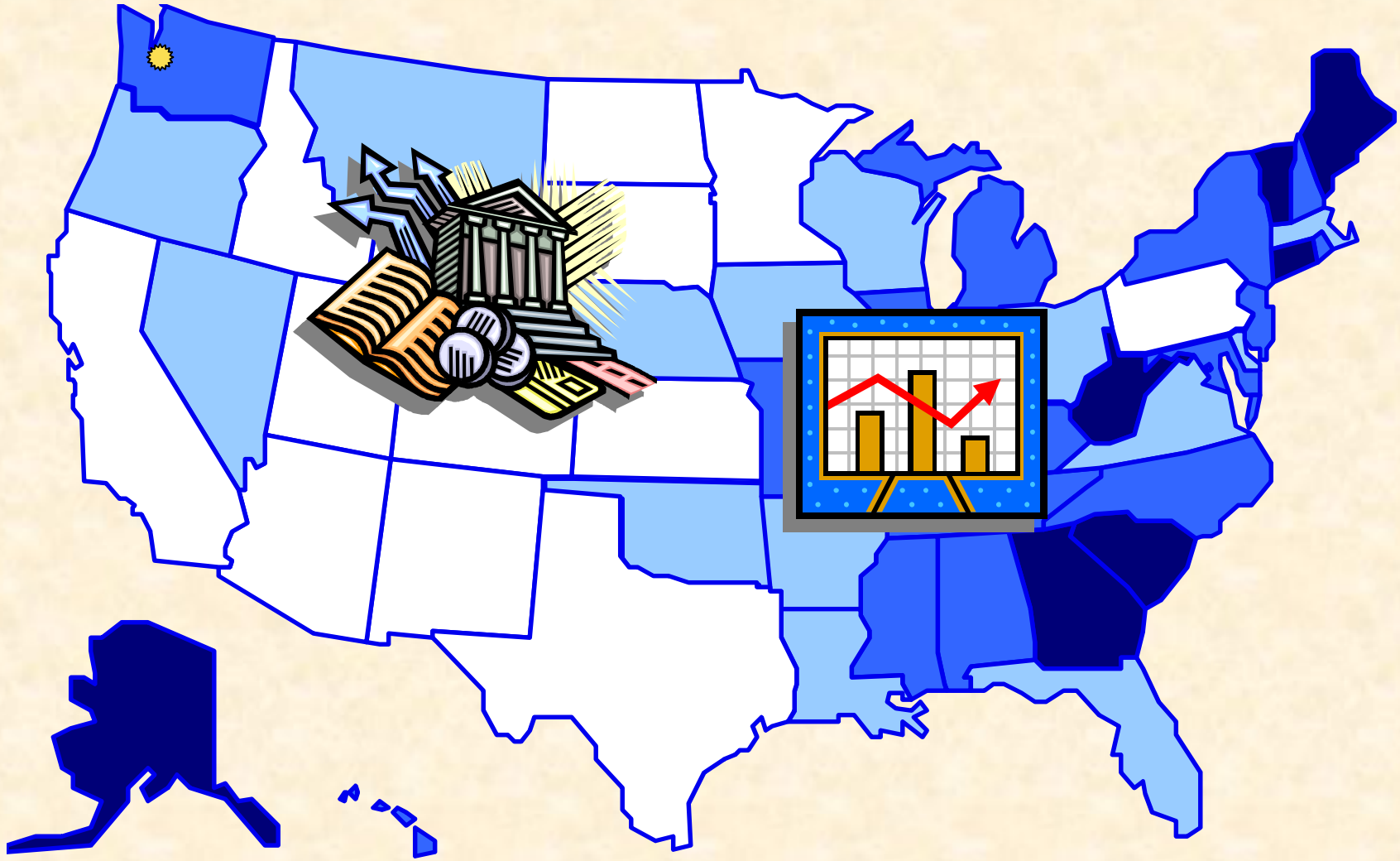
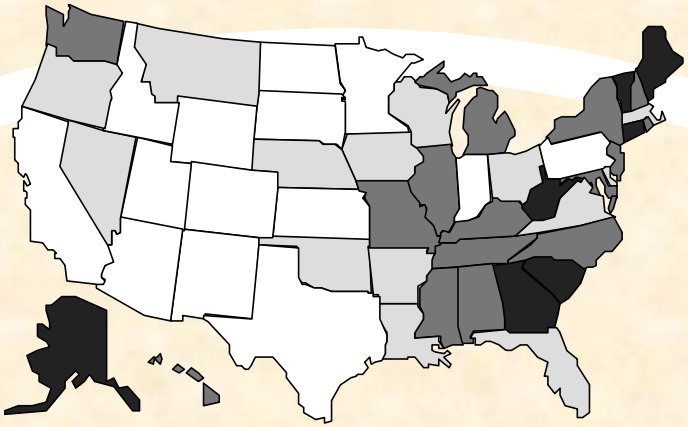
National CON Perspective and Experience

State Responses about CON Monitoring and Data





Thomas R. Piper

Principal, MacQuest Consulting

a presentation to the

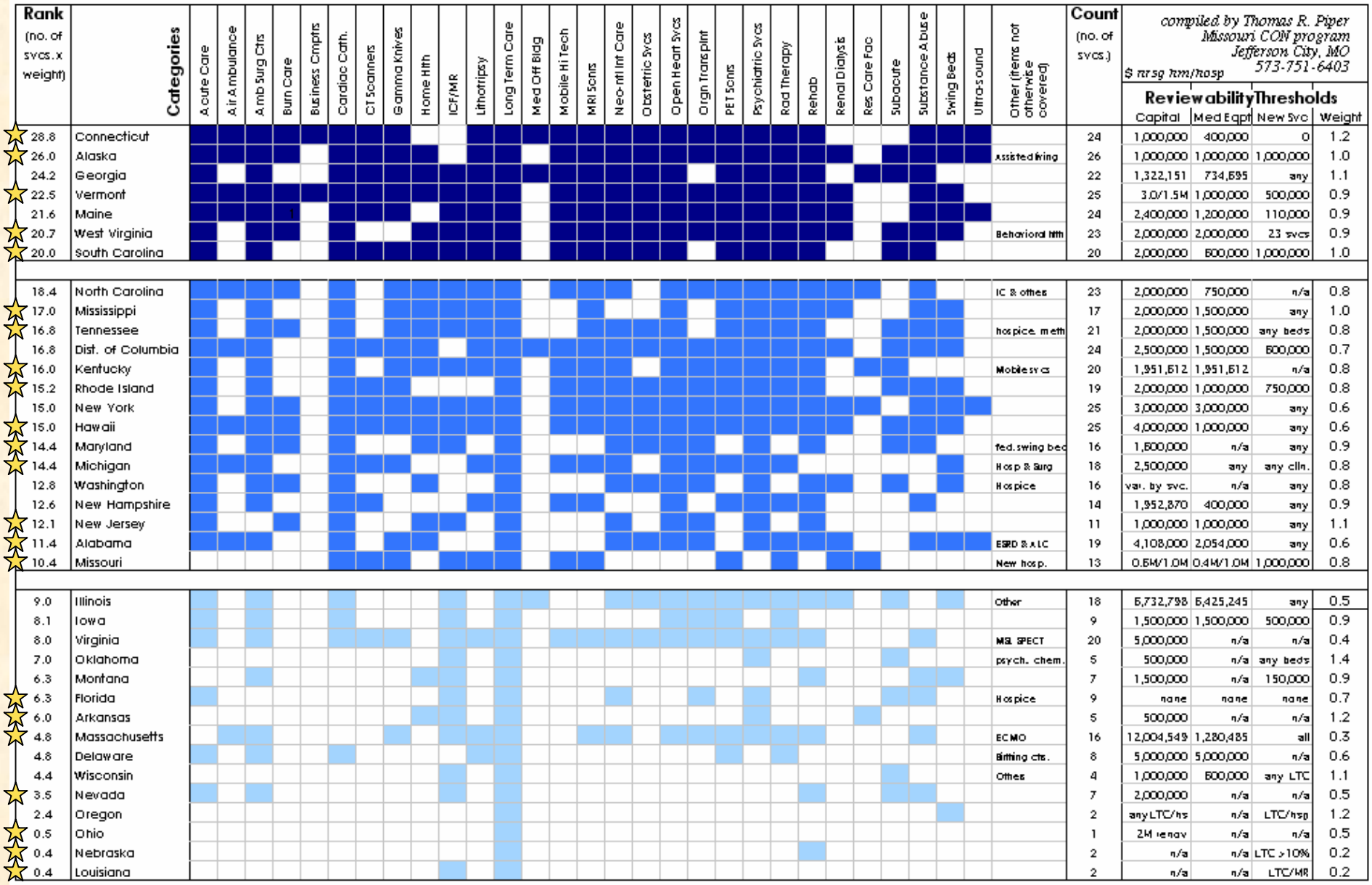
Washington State CON Task Force

Wednesday, May 17, 2006, SeaTac Hilton

The CON Matrix of

2005 Relative Scope and Review Thresholds: CON Regulated Services by State

(this information is summarized from the 2005 National Directory of Health Planning, Policy and Regulatory Agencies, the fifteenth edition published by the American Health Planning Association, also see map)



Rank (no. of svcs. x weight)	Categories	Acute Care	Air Ambulance	Amb Surg Ctrs	Burn Care	Business Cmptrs	Cardiac Cath.	CT Scanners	Gamma Knives	Home Hlth	ICF/MR	Lithotripsy	Long Term Care	Med Off Bldg	Mobile Hi Tech	MRI Scnrs	Neo-ntl Int Care	Obstetric Svcs	Open Heart Svcs	Organ Transplnt	PET Scnrs	Psychiatric Svcs	Rad Therapy	Rehab	Renal Dialysis	Res Care Fac	Subacute	Substance Abuse	Swing Beds	Ultra-sound	Other (items not otherwise covered)	Count (no. of svcs.)	compiled by Thomas R. Piper Missouri CON program Jefferson City, MO 573-751-6403 $ nrsg hm/hosp	Reviewability Thresholds Capital	Med Eqpt	New Svc	Weight
28.8	Connecticut	■	■	■	■	■	■	■	■			■	■	■	■	■	■	■	■	■	■	■	■	■				■	■	■		24	1,000,000	400,000	0	1.2
26.0	Alaska	■	■	■	■		■	■	■	■		■	■		■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	Assisted living	26	1,000,000	1,000,000	1,000,000	1.0
24.2	Georgia	■		■			■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■		■	■	■				22	1,322,151	734,695	any	1.1
22.5	Vermont	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■			■	■			25	3.0/1.5M	1,000,000	500,000	0.9
21.6	Maine	■	■	■	1		■	■	■		■	■	■		■	■	■	■	■	■	■	■	■	■	■			■	■	■		24	2,400,000	1,200,000	110,000	0.9
20.7	West Virginia	■		■	■		■			■	■	■	■		■	■	■	■	■	■	■	■	■	■	■		■	■	■		Behavioral hlth	23	2,000,000	2,000,000	23 svcs	0.9
20.0	South Carolina	■		■			■	■	■	■	■	■	■		■	■	■	■	■		■	■	■	■			■	■				20	2,000,000	600,000	1,000,000	1.0
18.4	North Carolina	■	■	■	■		■		■	■	■	■	■		■	■	■		■	■	■	■	■	■	■	■		■			IC & others	23	2,000,000	750,000	n/a	0.8
17.0	Mississippi	■		■			■		■	■	■	■	■			■		■		■	■	■	■	■	■			■	■			17	2,000,000	1,500,000	any	1.0
16.8	Tennessee	■		■	■		■		■	■	■	■	■			■	■	■	■		■	■	■	■			■	■	■		hospice, meth	21	2,000,000	1,500,000	any beds	0.8
16.8	Dist. of Columbia	■	■	■			■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■			24	2,500,000	1,500,000	600,000	0.7
16.0	Kentucky	■		■			■		■	■	■	■	■		■	■	■		■	■	■	■	■	■		■	■				Mobile svcs	20	1,951,612	1,951,612	n/a	0.8
15.2	Rhode Island	■		■			■	■	■				■		■	■	■	■	■	■	■	■	■	■			■	■	■			19	2,000,000	1,000,000	750,000	0.8
15.0	New York	■		■	■		■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■		■	■	■		25	3,000,000	3,000,000	any	0.6
15.0	Hawaii	■	■	■	■		■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■		■	■	■			25	4,000,000	1,000,000	any	0.6
14.4	Maryland	■		■	■		■			■	■		■			■	■	■	■	■		■		■			■	■			fed. swing bed	16	1,600,000	n/a	any	0.9
14.4	Michigan	■	■	■			■	■	■			■	■		■	■	■		■	■	■		■						■		Hosp & Surg	18	2,500,000	any	any clin.	0.8
12.8	Washington	■		■	■		■			■			■				■	■	■			■		■	■		■		■		Hospice	16	var. by svc.	n/a	any	0.8
12.6	New Hampshire	■		■			■	■				■	■		■	■			■		■	■	■					■				14	1,952,870	400,000	any	0.9
12.1	New Jersey	■			■		■			■	■		■				■		■	■		■		■								11	1,000,000	1,000,000	any	1.1
11.4	Alabama	■	■	■			■		■	■			■				■	■	■	■		■	■	■	■			■	■	■	ESRD & ALC	19	4,108,000	2,054,000	any	0.6
10.4	Missouri						■	■	■		■	■	■		■	■					■		■		■	■					New hosp.	13	0.6M/1.0M	0.4M/1.0M	1,000,000	0.8
9.0	Illinois	■		■			■				■		■	■			■	■	■	■	■	■	■	■			■		■		Other	18	6,732,798	6,425,245	any	0.5
8.1	Iowa	■		■			■				■		■						■	■	■		■									9	1,500,000	1,500,000	500,000	0.9
8.0	Virginia	■		■			■	■	■		■	■	■		■	■	■	■	■	■	■	■	■	■				■			MRI, SPECT	20	5,000,000	n/a	n/a	0.4
7.0	Oklahoma										■		■								■						■				psych. chem.	5	500,000	n/a	any beds	1.4
6.3	Montana			■						■	■		■											■				■	■			7	1,500,000	n/a	150,000	0.9
6.3	Florida	■									■		■				■			■		■					■	■			Hospice	9	none	none	none	0.7
6.0	Arkansas									■	■		■									■			■						5	500,000	n/a	n/a	1.2
4.8	Massachusetts		■	■					■		■	■	■			■	■		■	■	■	■	■	■				■			ECMO	16	12,004,549	1,280,485	all	0.3
4.8	Delaware	■		■			■					■	■							■		■									Birthing ctrs.	8	5,000,000	5,000,000	n/a	0.6
4.4	Wisconsin										■		■														■				Others	4	1,000,000	600,000	any LTC	1.1
3.5	Nevada	■		■							■		■											■			■	■				7	2,000,000	n/a	n/a	0.5
2.4	Oregon												■															■				2	any LTC/hs	n/a	LTC/hsp	1.2
0.5	Ohio												■																			1	2M renov	n/a	n/a	0.5
0.4	Nebraska												■											■								2	n/a	n/a	LTC >10%	0.2
0.4	Louisiana										■		■																			2	n/a	n/a	LTC/MR	0.2

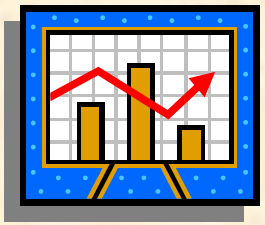
Disclaimer. Rank order relates to volume of items reviewed, NOT intensity of analysis or conclusions which are based on Criteria and Standards and decisions

Source. Updated January 19, 2005, using most recent information available

Four Specific Questions Asked

- The dimensions of your CON **compliance efforts** like type of follow-up, period of oversight and penalties for non-compliance?
- Any **feedback** of compliance back into your state health plan (or criteria and standards, if no plan)?
- What inventory and utilization **data systems** are available for your use in analyzing CON applications?
- What ongoing **communication** do you have with licensing, reimbursement and other state agencies about CON issues?

Handout provides detail behind this overview



State Responses to CON Monitoring Questions

On April 4, 2006, the inquiry below was emailed to each of the 37 Certificate of Need program directors in the country. As of April 29, responses have been received from 22 agencies as depicted in this final compilation (minor editing was done to improve readability; however, no changes were made to the intent).

I'm currently assembling perspectives on the relationship of CON compliance efforts, data resources and communication . . . could you briefly describe for me:

1. *The dimensions of your CON compliance efforts like type of follow-up, period of oversight and penalties for non-compliance? Any feedback of compliance back into your state health plan (or criteria and standards, if no plan)?*
2. *What inventory and utilization data systems are available for your use in analyzing CON applications?*
3. *What ongoing communication do you have with licensing, reimbursement and other state agencies about CON issues?*

The compiled responses are listed below alphabetically by state with the columns arranged across in the order of the questions posed above.

State (respondant)	Dimensions of compliance efforts by Certificate of Need agencies	Feedback to state health plan	Inventory and utilization data systems for CON reviews	Communication with other state agencies about CON
Alabama (Paul May)	Agency follows up every six months after issuance of certificate of need until project is completed. If project has cost overruns of 10% or greater, the applicant must pay a cost overrun fee of 10% of the overrun and the filing of a certificate of need application. Through the review of annual report from health care facilities, the number of beds and services provided are verified for certificate of need compliance.	(no response)	The number of beds, occupancy rates, average daily census, financial information, costs, revenue, equipment, and census, including race breakdowns and utilization facors. We also conduct a Patient Origin Survey four times a year on hospital inpatients.	We send copies of reviewability determinations, notices of changes of ownership, and certificates of need to the Department of Public Health (licensing entity), Blue Cross/Blue Shield of Alabama and, when applicable, to Alabama Medicaid Agency and Department of Mental Health and Mental Retardation. Also, when applicable, we provide a copy of the review schedule and certificate of need application to the Medicaid Agency and Mental Health Department.
Alaska (David Pierce)	The main penalties for non-compliance are: 1) injunction can be filed; 2) Medicaid payments withheld. We do have a follow-up clause in our CON process to allow staff to do a site visit on the project.	(no response)	We are implementing a new utilization data system that covers all types of services reviewed under CON. It will eventually have all of the latest annual data and will be published on the web. All facilities are required to participate.	We work closely with all of the agencies mentioned in the question, and regularly coordinate our efforts including being sure CON is mentioned in the other agencies regulations where needed.
Arkansas (Mary Brizzi)	Our Rules allow nine months from the date the CON (Permit of Authority) is issued to sign a construction contract, six months from that point to complete the foundation and 12 months from that point to apply for licensure on the project. If any of these deadlines will not be met, an extension can be requested. The Commission can grant an extension of up to six months at any of the deadlines. Our POA compliance efforts consist of letters that are sent prior to the deadlines. If an extension is not requested or granted, the Permit of Approval is subject to termination.	(no response)	Utilization data for nursing homes and assisted living facilities is available from The Office of Long Term Care at the Department of Health and Human Services. We administer a survey to psychiatric residential treatment facilities, hospices and home health agencies to get utilization data. We also use national cost-per-day data about hospice and home health in the application review process.	There are open lines of communication with some of the licensing agencies, especially The Office of Long Term Care. When a license changes, those changes are automatically sent to this office. The psychiatric residential treatment facility licensing entity does not communicate with our office. We have to contact them if we need information. All licensing agencies are willing to share information with us. The Medicaid office is also willing to share information, if it is requested, like the figures for nursing homes.

Dimensions of compliance efforts by CON agencies

- **Progress reports for issued CONs until service becomes operational:**
  - monthly (12 per year)
  - quarterly (3 per year)
  - 6-month (2 per year)
  - annually (1 per year)

- **Documentation requirements:**
  - capital cost expenditures/commitments
  - purchase/acquisition verifications
  - percentage of completion
  - third-party validations

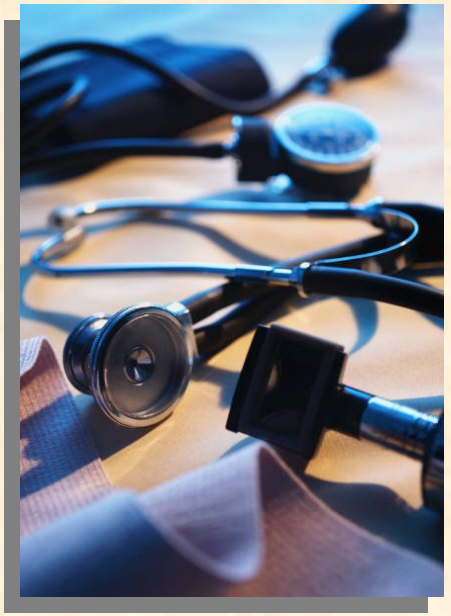
- **Pre-operational modifications:**
  - development schedule changes
  - change of site/ownership
  - change of scope
  - cost overruns
  - extensions

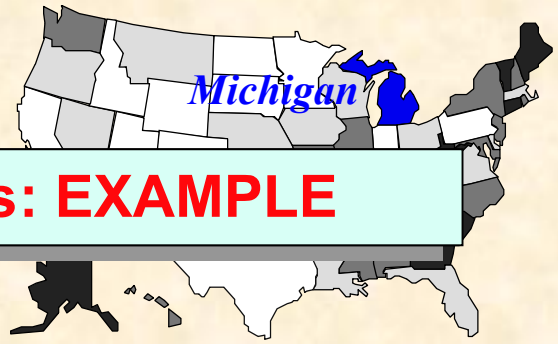
Dimensions of compliance efforts (continued)

- **Conditions applied to approved CON:**
  - progress reports during project development
  - performance reporting stipulations
  - charity/uncompensated care provisions
  - Medicaid/other reimbursement
  - completion due dates

- **Operational monitoring periods:**
  - post-completion site visits
  - generally 0-5 years of direct oversight
  - data systems used to gain objective reports
  - licensure and reimbursement cross-checks

- **Penalties for non-compliance:**
  - additional fees for cost overruns
  - temporary suspension
  - revocation of CON
  - civil fines





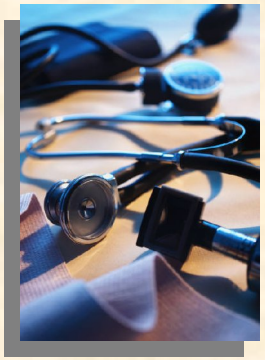
Dimensions of compliance efforts: EXAMPLE

Follow up:

1) 11-months after approval, see if project is 100% complete;
2) if not, require an enforceable contract that spells out start date for construction or equipment to be installed;
3) two years after approval, check to see if project is 100% complete, construction started, equipment installed; and
4) if project is not 100% and construction is started within two years, next follow-up date is targeted completion date in application.

Follow-up documentation required:

1) copy of executed lease/purchase agreements;
2) copy of license;
3) copy of construction permit;
4) copy of radiation safety certificate;
5) final accounting of project costs and sources of funds;
6) vendor installation date; and
7) start of clinical operations and completion date of project.



Penalties:

1) expire or revoke CON for noncompliance; and
2) civil fines, quarterly reporting of data, charity care for noncompliance

Feedback to state health plan and others

- **Periodic updating of state health or medical facilities plan:**
  - monitoring information influences process
  - provider feedback very important
  - issues and lessons learned

- **Improvement of criteria and standards:**
  - utilization data helps adjust factors
  - cooperative experience is considered
  - information a good reference point

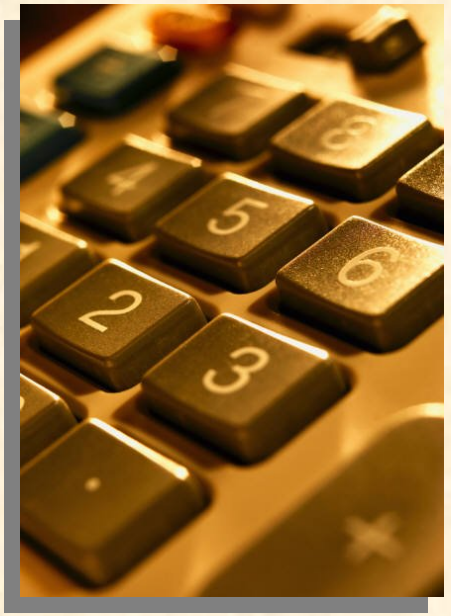
- **No response:**
  - over half bypassed this question

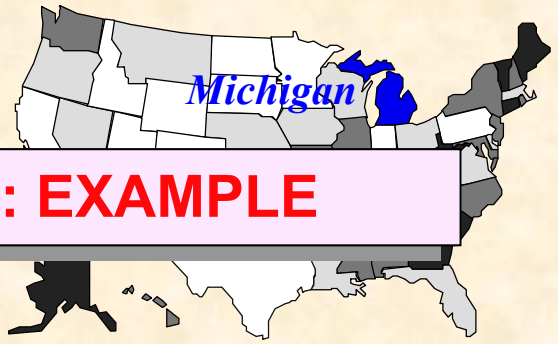
Inventory/utilization data systems for CON reviews

- **Types of data currently being collected:**
  - mostly institutional (hospital and nursing home)
  - inventory (size and location of service)
  - utilization (number of procedures)
  - patient origin (mostly hospitals)
  - mostly inpatient (very little outpatient)

- **Collection techniques:**
  - often based on CON surveys
  - electronic submission increasing
  - information a good reference point
  - some are specialized by service type

- **Data dissemination:**
  - web-based transparency expanding
  - some proprietary info (difficult to access)
  - paper publication diminishing

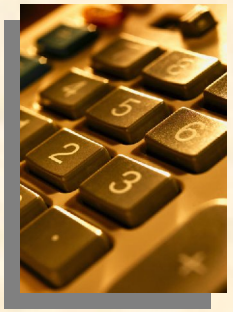




Inventory/utilization data system: EXAMPLE

1) The **Michigan Inpatient Data Base** (MIDB) includes primarily all **hospital discharges** in Michigan. It is purchased by the Department annually from the Michigan Health and Hospital Association. It is used to determine need for open heart, cardiac cath, hospital beds, NICU beds, lithotripsy, etc. 2004 is the most current MIDB data available.

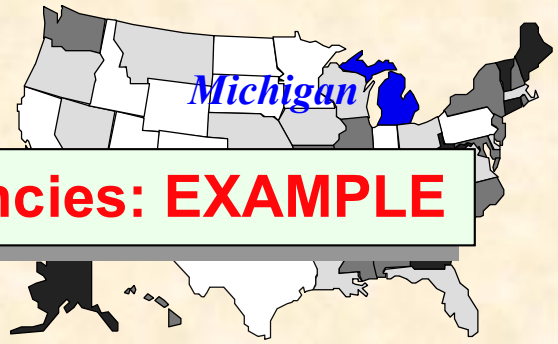
2) The **MRI Utilization Data Base** was created and is maintained by the Department. All MR providers must submit quarterly to this system. Twice a year, the Department publishes a utilization list from this system that is used to demonstrate need and also for compliance. The MR providers report approximately 600,000 scans through this system annually. It is a highly complex system that redistributes excess volume back (by provider) to be secured by applicants. It is this **tight surveillance monitoring system** that helped Duke conclude in their study a few years back that Michigan has been able to control the growth of MR services when compared nationally. 2005 is the most current MR data available.



3) The **Annual CON Hospital and Freestanding Questionnaire** is the primary tool for compliance, and for other services, such as surgical, to demonstrate need. The paper survey was replaced by an electronic survey this year. They are currently working with a contractor to create a web-based survey that should improve turnaround time. 2004 is the most current survey data available.

Communication with other state agencies about CON

- **Types of inter-agency communication:**
  - meetings (daily, weekly, monthly)
  - co-location (in same department)
  - notifications (CON action notes)
  - consultation (email, telephone)
  - generally frequent/inter-active
- **Types of government agencies:**
  - certificate of need
  - facility/service licensure
  - reimbursement
- **Characterization of relationships:**
  - open
  - close
  - crucial
  - active
  - positive
  - direct
  - follow-up



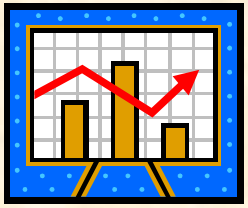
Communication with other state agencies: EXAMPLE

1) All CON **approvals are copied** to other applicable state agencies, including finance authority, environmental quality, Medicaid reimbursement, and licensing authorities

2) CON is **located within the bureau** that also contains licensing and certification for health facilities, nursing home monitoring, engineering, radiation safety. Hold weekly meeting with Bureau director that including licensing, engineering and radiation safety. Fire safety is coordinated through our engineering section. In addition, these other authorities have access to the online CON management information system (web-based).

Communication very good!!!

Summary of Observations



- 60% of the CON states responded to the one-month email survey, and were evenly distributed across the wide scope of services
- Level of detail ranged from simple to complex
- Each CON state has an accountable progress reporting system during completion of the project with opportunities for modification and penalties for non-compliance
- Many states monitor service performance operations
- Few have a clear feedback system to their criteria and standards
- Large number of state data systems were CON-generated
- All states described extensive inter-agency communication

promoting responsive planning,
evaluating health systems and reducing unnecessary health costs

QuickTime™ and a
TIFF (Uncompressed) decompressor
are needed to see this picture.

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